

STATE OF WEST VIRGINIA  
HEALTH CARE AUTHORITY  
CERTIFICATE OF NEED PROGRAM

***HOME HEALTH SERVICES***  
***APPLICATION***

Application for Expedited CON Review

CASE FILE NUMBER: \_\_\_\_\_  
(Assigned upon receipt of letter of intent)

### **GENERAL INFORMATION**

1. This is a Certificate of Need application for the development of home health agency. **ALL QUESTIONS** in this application must be addressed.
2. A letter of intent must be submitted at least fifteen (15) days prior to the application. The letter of intent must include enough information to indicate the name of the project, its approximate location, nature, scope, cost and the time frame for the development of the service.
3. The Certificate of Need staff will review the application for completeness upon its receipt. Within fifteen (15) days, the application will either be declared complete or a request for additional information will be issued.
4. This is an application for an expedited review. If it is determined that the project described in this form is not eligible for a expedited review, then an order will be issued requiring the application to undergo a standard review.
5. Any amendment to the application must be made in writing. If an amendment is deemed to be substantial by the Certificate of Need Program, the review of the application may be extended or the application may be withdrawn and made subject to a new review cycle.
6. An applicant may withdraw its application at any time without prejudice. Applicants must notify the Certificate of Need Program in writing of such action.
7. Assemble the application in the same sequence as this form. In the upper right hand corner of each page, including attachments, specify the page number. In the upper left hand corner of each page, repeat the facility name and case file number. Response to items should be provided repeating each question before providing your response.
8. Applicants must provide a signed original as well as three (3) copies of the entire application to:

Dayle Stepp, Certificate of Need Program  
West Virginia Health Care Authority  
100 Dee Drive  
Charleston, WV 25311-1692

These copies should be submitted in the following manner:

- a. The original application must be in a three-ring, hard-back notebook with alphabetized section dividers.
  - b. Three (3) copies are to be submitted unbound and unstapled.
9. Applicants must be also provide one (1) copy of the entire application to:
- Offices of the Insurance Commissioner  
Consumer Advocacy Division  
Post Office Box 50540  
Charleston, West Virginia 25305
10. The application and any other material in the case file become public documents and are available for inspection and copying upon request.
11. Data, State Health Plan Standards, and approved need methodologies will provided by the Authority upon request only.
12. Certificate of Need law and regulations may be obtained by contacting:
- Administrative Law Division  
Secretary of State's Office  
Building 1, Suite 157-K  
Charleston, West Virginia 25305  
(304) 558-6000

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1. **IDENTIFICATION OF THE APPLICANT**

- A. \_\_\_\_\_  
Name of Facility at Which Project Will Be Developed
- \_\_\_\_\_  
Address of Facility
- \_\_\_\_\_  
Project Name
- B. \_\_\_\_\_  
Name of Applicant
- \_\_\_\_\_  
Address of Applicant
- \_\_\_\_\_  
Name and Title of Chief Executive Officer      Telephone
- C. \_\_\_\_\_  
Contact Person
- \_\_\_\_\_  
Address      Telephone
- D. Type of Organization
- | PROPRIETARY          | NON-PROFIT          | GOVERNMENTAL        |
|----------------------|---------------------|---------------------|
| ___ Individual       | ___ Corporation     | ___ State           |
| ___ Partnership      | ___ Church          | ___ County          |
| ___ Corporation      | ___ Other (Specify) | ___ Other (Specify) |
| ___ Other (Specific) |                     |                     |
- E. \_\_\_\_\_  
Medicare/Medicaid Provider Numbers

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**2. AUTHORIZATION**

- A. Attach articles of Certificate of Incorporation or filed articles of general or limited partnership.
- B. List members of board of directors of the corporation, or general partners if a general or limited partnership.
- C. Attach a copy of the resolution or minutes of the governing body meeting(s) wherein this project was approved. Also included authorization designating the signer of the application and contact person in question #1 to act on behalf of the applicant.

**3. PROJECT DESCRIPTION**

Generally describe the project. Include (a) specific services to be provided, (b) proposed service area and population to be served, (c) capacity of the proposed service(s), (d) capital expenditure, (e) projected annual operating expense for the first five (5) years of operation, and (f) general organization and management structure.

**4. PROJECT COST**

- A. Provide information regarding the capital expenditure associated with this project including a listing of equipment.
- B. Provide information regarding office space including a copy of lease or rent agreement.

**5. FINANCING**

- A. If there is a capital expenditure associated with the proposal, complete Table 5.
- B. Indicate the project's requirement for new working capital, including requirement due to start-up expenses. Indicate source of funds. If working capital is to be borrowed, indicate principal, interest rate and term. Also indicate the total working capital to be financed.

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**6. TIMETABLE**

Provide a timetable for implementation of this project in Table 6.

**7. NEED ANALYSIS**

Provide an analysis of the need for the proposed service by county using the methodology contained in the State Health Plan.

Approved by the Governor

Date: 11/13/96

**HOME HEALTH SERVICES****I. INTRODUCTION**

Planning for the provision of health care services has often been related to identifying duplicative services and cost containment measures. However, the primary goal of the planning process should be for the establishment of a rational allocation of services and resources, noting of course, that prevention of duplicative services and cost containment measures play a key role. New and expanded services and facilities should serve the public interest. The focus on containing health care costs through efficient utilization of resources while ensuring the availability of adequate and quality health care services must be the underpinning of health planning. The goal is to encourage a system that provides more effective and appropriate care and more accountability for the outcomes and costs incurred.

The standards written to address these principles and goals must demonstrate the following: consistency with the State Health Plan, need and accessibility, health care/social services systems' interrelationships and linkages, costs, economic feasibility, resource availability and quality of services. These standards should complement and coordinate with the fiscal plans of appropriate state planning, regulatory, and payor agencies.

These standards address an immediate need to regulate the full range of home health services. They will need revision to further address the additional issues of competition, economies of scale, integrated systems, consolidation, and the special needs and circumstances of home health care providers and managed care organizations as the home health delivery system evolves during a period of significant

change based on market forces. These revisions will be submitted to Governor Caperton by October 31, 1996.

## II. DEFINITIONS

A. Additional office: May include but is not limited to sub-units, branches, satellites, and is defined for purposes of these standards as any additional office located in West Virginia and identified with the home health agency.

B. Capital expenditure: An expenditure by or on behalf of a health care facility which under generally accepted accounting principles is not properly chargeable as an expense of operation and maintenance, and as more fully set out in West Virginia Code §16-2D-2(f).

C. Coordination and standardization of care: The provision of home health services in accordance with patients' need and with protocols established by a home health agency so that all patients of the agency receive the following aspects of service in a standardized, consistent manner: screening for agency admission and discharge, case management if applicable, follow-up of health related problems, and referrals to other agencies and service providers for care that is not offered by the home health agency.

D. Plan of care: Originally called plan of treatment and changed by Medicare statute to plan of care; is developed in consultation with the agency staff and covers all pertinent diagnosis, types of services and equipment required, frequency of visits, prognosis, rehabilitation potential, functional limitations, activities permitted, nutritional requirements, medications and treatments.

E. Home health agency: An organization primarily engaged in providing professional nursing services either directly or through contract arrangements and at least one (1) of the following services: home health aide services, other therapeutic services, physical therapy, speech therapy, occupational therapy, and nutritional services or medical social services to persons in their place of residence on a part-time or intermittent basis.

F. Office: Place of business which is staffed and equipped to provide the identified services in the manner stated in the application for Certificate of Need.

G. Patients' rights: The level of treatment and care that patients are entitled to receive, written and verbal information in a language patients can understand, the right of patients to express grievances, and the manner in which corrective action is taken.

H. Service area: County/counties in which an application for certificate of need has been made or granted and/or in which a facility has expanded through a determination of nonreviewability.

### III. CERTIFICATE OF NEED APPLICATION PROCESS

A. Determination of Reviewability: Organizations planning relocation of offices, service changes, acquisitions, and/or addition/deletion of any new services need to submit a request to the Authority for a determination of reviewability prior to initiating any action. That request should be concluded with a notarized verification of the signature of the person authorized by the provider organization to sign in its behalf pursuant to W. Va. C.S.R. 65-7-25. Additional offices within an existing approved service area may be added without undergoing certificate of need review; the Authority should be notified of these additional offices by the organization submitting a request for a determination of reviewability.

B. Letter of Intent: The initial step in the Certificate of Need Process is the submission to the Authority of a letter of intent. The letter should include:

1. Name and brief description of the entity applying for the certificate of need;
2. Brief description of the proposed project, including anticipated individuals to be served and services to be provided;
3. Identifying the county(ies) in the proposed service area;
4. Estimate of anticipated capital expenditure associated with the project; and,
5. Signature of individual authorized to sign for the organization.

C. Application: The Authority reviews the letter of intent and determines the type of application which is appropriate. An application form and certain data and materials which should be helpful in its completion are sent to the applicant. The receipt by the Authority of a completed application and accompanying application filing fee initiates the CON application review process. For details on time frames, notices, hearings and appeal processes, refer to W. Va. Code §16-2D-1 et seq. and 65 C.S.R. 7.

D. Decisions: Decisions of the Authority are issued in the form of orders which outline the details of applications, the Authority analysis, findings and conclusions, the decision and opportunities for reconsideration and/or appeals. No decision will be issued to an entity which is not in full compliance with the Health Care Financial Disclosure Act (West Virginia Code §16-5F-1 et seq.).



E. Public Notices: Actions of the Authority, including receipt of letters of intent, applications declared complete, decisions of the Board, scheduled hearings and time frames for hearing requests appear in the "Health Care Cost Review" newsletter published weekly by the Authority, in the State Register, and in the Charleston newspapers every Saturday.

#### IV. Certificate of Need Application Review Process

##### A. Minimum criteria for review

West Virginia Code §16-2D-6 and 9 contain the statutory review criteria. West Virginia Code §16-2D-9(b) requires that an applicant demonstrate need and consistency with the State Health Plan. Additionally, the Authority must make the West Virginia Code §16-2D-6(e) findings in order for a CON to be granted.

In the Certificate of Need determinations issued by the Health Care Authority, the following, inter alia, is taken into consideration:

1. The proposed facility/service(s) demonstrates an analysis of the needs of the population to be served;
2. A need for the proposed facility/service(s) still exists in the proposed service area after a determination that there is efficient utilization of resources currently providing the same or similar service to the same or similar population;
3. The proposed facility/service(s) would not result in overcapacity within the service area; and,
4. The costs of the proposed facility/services(s) are reasonable and will not increase patient cost.

##### B. Recommendations from state regulatory, planning and payor agencies

One aspect of the analysis is a coordinated review by regulatory, planning and payor agencies of state government. The Authority takes into consideration in reviewing CON applications, the programmatic and fiscal plans of appropriate state agencies. Any recommendations sought are for "comment only" purposes. The Authority has final approval on applications.

#### V. NEED METHODOLOGY

Planning is particularly crucial for those segments of the health care system which are rapidly growing, such as home health care. Planning methodology and criteria should ensure that there are an adequate number of providers of quality health

programs with services readily accessible to those in need. Planned growth of home health services helps contain health care costs.

Since the primary payors for home health care services (Medicare and Medicaid) currently operate on a cost reimbursement system, increased competition does not create cost savings, but may well increase the cost per unit of service. Expansion of services and the addition of new providers should be planned such that they occur in areas with clearly documented unmet need. The need should be based on measurable and readily available data in such a manner that the health care system is not negatively impacted.

A. ASSUMPTIONS

The assumptions underlying the projection of need for home health facility/service(s) are as follows:

- ? The need for home health facility/services will be determined on a county by county basis.
- ? More than one county may be included in an application; service areas must consist of contiguous counties. Documentation of need is required for each county included in the application.
- ? The smallest service area for an application to provide home health services shall be one (1) county.
- ? The unmet need for home health services in a county is determined by a process that compares current county-to-state utilization data.
- ? An adjustment of 229 home health recipients has been added to the formula to allow for the development of agencies approved for CON in the previous 12 months. An unmet need will exist if the need methodology yields a threshold of at least 229 projected home health recipients. The threshold/adjustment factor of 229 is the median number of home health recipients receiving care from an agency identified in the 1995 West Virginia Health Care Authority Home Health Services Survey Summary. The Authority shall consider adjusting the threshold/adjustment factor at the time it updates the need calculations.
- ? Population data are for the year 1995.
- ? Data sources are obtained from the Authority documents listed in the Sources of Data below.

B. SOURCES OF DATA

The Authority will provide the applicant with the following:

1. Agencies Awarded a Certificate of Need To Provide Home Health Services: Authority listing of agencies having a certificate of need to provide home health services and their authorized service areas as well as a listing of agencies receiving CON approval in the previous 12 months.
2. West Virginia Health Care Authority Population Projections By County: Official Authority population projections by county (1990-2020).
3. West Virginia Health Care Authority Home Health Services Survey Summary: Annual Authority document required of home health agencies providing services to West Virginia residents which contains operation, utilization, and financial data.

C. DETERMINING UNMET NEED FOR HOME HEALTH SERVICES

Need calculations based on 1995 data have been completed by Authority using the following methodology. (See appendix for calculations). The Authority shall update the need calculations and shall consider updating the threshold/adjustment factor on a yearly basis. These calculations performed by the Authority shall be used to determine unmet need; this is the only demonstration of need that the Authority shall consider. They shall remain in effect until updated by the Authority.

The need methodology is comprised of four (4) calculations. The four calculations must be completed for each county to be served. As the Authority is responsible for performing and providing the need calculations, pursuant to the methodology, one need only look to the calculations in the Appendix to determine if a need exists in a certain county. The Authority has, however, provided the methodology within these standards for the public's information. A description of the methodology follows.

Calculation 1 compares the county and state home health utilization rates.

Calculation 2 determines the extent of potential home health recipients in the county to reach the state utilization level.

Calculation 3 determines the number of home health recipients in the county below the state home health utilization rate.

Calculation 4 involves an adjustment factor for the agencies receiving Certificate of Need approval in the previous 12 months to allow for their initiation and development of home health services. Each agency is allowed a 229 home health recipient adjustment factor for each county in the approved service area. An unmet need or threshold of at least 229 projected home health recipients must occur in the county before consideration will be given to issuing another Certificate of Need for the county.

The following is the methodology employed by Authority to determine if a need exists in a specific county. An example using Berkeley County is included in the Appendix.

1. CALCULATION OF THE ACTUAL TOTAL COUNTY HOME HEALTH UTILIZATION RATE

(This compares current county and state home health utilization rate).a.

Show total number of home health recipients for county for current year from the Authority Home Health Survey.

b. Show county population for current year.

c. Divide a by b.

d. Multiply c by 1000 for the current county home health utilization rate.

e. List current state home health utilization rate from Authority Home Health Survey.

f. Is the current county home health utilization rate below the state rate? yes/no

If yes, continue with the following. If no, an unmet need does not exist.

2. CALCULATION OF THE ACTUAL NUMBER OF HOME HEALTH RECIPIENTS NEEDED TO OBTAIN THE STATE UTILIZATION RATE.

A. Components of formula - a, b, c.

a = List number of current home health recipients for county for current year (1.a)

b = List county home health utilization rate for current year (1.d)

c = List state home health utilization rate for current year (1.e)

Formula  $a \times c / b = d$

1. Multiply a x c

2. Divide a x c by b

d = Number of home health recipients for county to meet state utilization rate

3. CALCULATION OF THE ACTUAL NUMBER OF HOME HEALTH RECIPIENTS BELOW THE STATE RATE.

Formula  $a - b = c$

a. List number of home health recipients for county to obtain state rate (2.d)

- b. List current number of home health recipients for county (1.a)
- c. Subtract b from a to obtain the number of current county home health recipients below the state rate.

4. CALCULATION OF THE THRESHOLD (ADJUSTMENT FACTOR)  
 (This calculation is done only if there are agencies in the proposed county which received CON approval in the previous 12 months.)

Formula  $a - b = c$

- a. List the current county home health recipients below state rate (3.c)
- b. Subtract adjustment factor for agencies receiving CON approval in previous 12 months.
- c. Number above threshold adjustment.

Conclusion:

If the threshold is at least 229 projected home health recipients, an unmet need exists.

## VI. QUALITY AND ACCESS

### A. REQUIREMENTS

All applicants shall demonstrate that they will meet the following requirements:

1. All home health care facility/services(s) must:
  - a. apply for a Certificate of Need;
  - b. meet current Medicare certification requirements and standards; and,
  - c. notify Office of Health Facility Licensure and Certification.
2. The applicant must submit a copy of a West Virginia certificate of authority and/or business license in accordance with West Virginia Code §1-1-53.
3. Applicants must clearly identify their company (including all existing subsidiaries) and list all names used, i.e., doing business as (d/b/a) and any and all linkages.
4. If the applicant's main office is located outside the boundaries of West Virginia, an in-state office in the proposed service area must be established before services can be provided.

5. No person can be denied services on the basis of age, sex, race, nationality, ability to pay, disability/diagnosis or geographic area of residence.
6. Home health facility/service(s) must cover the geographic area of an entire county and must serve residents throughout the entire county.
7. Home health facility/service(s) must make available their array of services to all patients.
8. Home health facility/service(s) must participate in the provision of services to the patient who does not have the means to pay for care, i.e., charity care.
9. The home health facility/services(s) must ensure all professional employees and personnel, staff and contract, have current licenses and /or registration.
10. The home health facility/service(s) must assure that patients' rights are protected and promoted by providing documentation to the patient of his/her rights. The home health facility/service(s) must make available a corrective action to all patients if applicable.
11. The provision of home health services must be coordinated and standardized so that all patients receive services in a consistent manner.
12. Services must be delivered in a manner that maintains the patients' privacy, confidentiality, and dignity.
13. The established plan of care must note participants in the plan, how it is updated, and what procedures are followed when the plan needs to be altered.
14. There must be a mechanism for handling emergencies on a 24 hours per day, 7 days per week, basis.
15. The provision of home health service(s) to a patient must be directed by a physician. One or more professional nurses must supervise the delivery of these services.
16. An in-service educational program for full-time, part-time, and contractual staff must be conducted on an ongoing basis.
17. There must be clearly identified lines of authority between administration, professional staff, and the programs/units/divisions.

18. There must be a quality assurance program which includes a review mechanism for the patient's medical plan of care.
19. A description of the health care delivery system must be submitted which includes the number and kinds of physicians, the number of nurses, therapists, and the identification of all the health care facilities/services in the proposed service area. Describe how the proposed home health service will integrate with the current health care delivery system.

#### VII. FINANCIAL FEASIBILITY

The applicant must demonstrate the financial feasibility of the project by the conclusion of the third years' operation. The factors to be considered must include:

1. Utilization by discipline by payor classification.
2. Current and projected rates.
3. Statements of (a) revenues and expenses, (b) balance sheets, (c) statements of changes in fund balances, and (d) statements of cash flow for each of last two fiscal years. Audited financial statements, if prepared, must be submitted. If 10-K Reports are required to be submitted to the Securities Exchange Commission by either the applicant or a related entity, these must be submitted for the preceding three (3) years.
4. A preliminary financial feasibility study which must, at a minimum, include: (a) revenues and expenses, (b) balances sheets, (c) statements of changes in fund balances, and, (d) statements of cash flow for each of the last two fiscal years, the current fiscal year and future fiscal years prior to the project's implementation, and the first three years after the project's implementation. The financial feasibility study must take the form of a compiled forecast with all disclosures, as those terms are defined by the American Institute of Certified Public Accountants and must also include all assumptions used, including projected payor mix, charges and/or revenues for each category of payor.
5. Sources of revenue/reimbursement by payor classification.
6. The applicant must demonstrate that the costs and charges associated with the project are comparable to the costs and charges of similar providers offering similar services.
7. The applicant must demonstrate compliance with W. Va. Code 16-5F-1 et seq., "The Health Care Financial Disclosure Act," and 65 C.S.R. 13, the "Financial Disclosure Rule."

8. The applicant shall develop a policy regarding charity patients. The policy must address the issues of sliding scale fee schedules and/or free care to the extent that such care is financially feasible.
9. Preference will be given to applicants who demonstrate intent to provide a full array of services to all patients, without regard to their ability to pay.

VIII. SUBSTANTIAL COMPLIANCE

Any person holding a CON for home health services is required to submit to the Authority a written progress report outlining the progress toward completion of the approved project, according to the timetable outlined in the application. 65 C.S.R. 7-20.1.

In addition to the information required to be included in the report, pursuant to regulation, the applicant shall include the following:

1. Utilization, by discipline by payor classification, from the date of issuance of the CON to the date of the progress report;
2. Evidence of Medicare certification, if applicable;
3. Evidence of notification of the Office of Health Care Facility Licensure and Certification;
4. Evidence of scope of coverage of counties within service area;
5. Evidence of an in-state office, if an out-of-state facility;
6. Number of referrals (by service category) and identification of sources of referrals from the date of issuance of the CON to the date of the progress report;
7. Number of full-time and part-time administrative staff, professional service staff, and contractual staff, and staff to patient ratio, all as the date of the progress report;
8. Evidence with respect to the provision of array of home health services;
9. Current rates;
10. Sources of revenue/reimbursement by payor classification, amounts for bad debt and charity care; and,



11. Copies of all survey, audits or reports that have been issued by regulatory agencies with respect to the project.

If the Authority finds that the project is not in substantial compliance with its CON, the Authority may withdraw the CON and the Authority may direct that any license to operate the new service be revoked or denied, or the Authority may impose fines and/or seek an injunction against the use or operation of the new service.

## IX. APPENDIX

### Part I. Information Sources

West Virginia Board of Physical Therapists  
Box 306  
Lost Creek , WV 26385

West Virginia Board of Examiners for Licensed Practical Nurses  
101 Dee Drive  
Charleston, WV 25311

West Virginia Board of Examiners for Registered Professional Nurses  
101 Dee Drive  
Charleston, WV 25311

West Virginia Board of Occupational Therapy  
119 South Price Street  
Kingwood, WV 26531

West Virginia Board of Social Work Examiners  
Post Office Box 5459  
Charleston, WV 25361

West Virginia Speech-Language-Hearing Association  
c/o Department of Speech Pathology and Audiology  
805 Allen Hall  
West Virginia University  
Morgantown, WV 26506

West Virginia Medical Institute is an organization that has a contract with the Health Care Financing Administration to review the health care services or items furnished or proposed to be furnished to Medicare beneficiaries.

West Virginia Office of Health Facility Licensure and Certification reviews and acts on recommendations regarding participation in Medicare and Medicaid programs

for home health agencies. The state agency used by HCFA to perform survey and review functions for Medicare.

West Virginia Department of Health and Human Resources Bureau For Medical Services is West Virginia's Medicaid agency.

Part 2. Identification of Surveys and Audits

West Virginia Health Care Authority Home Health Services Survey.

Facility/service(s) receiving certificate of need approval shall be required to complete and return the Authority's Survey of Home Health Agencies and to submit a complete cost report on an annual basis, or more frequently, if requested by the Authority. Unless otherwise specified by the Authority a separate survey shall be completed for each county served by the agency. This survey may include, but not be limited to, questions regarding the number of clients served according to age groupings, types (for example, skilled nursing, occupational therapy and social work), unskilled and number of visits provided, number of visits according to reimbursement source (including no-pay visits to medically indigent patients), and agency charges for services rendered.

West Virginia Office of Health Facility Licensure and Certification.

Oversight reviews are performed at predescribed intervals, and are based on detailed facility certification inspections, correspondence, complaint investigations, supporting certification file data and the degree of compliance that these facilities demonstrate. Appropriate action for noncompliance may consist of intermediate sanctions (monetary fines or decertification).

X. NEED METHODOLOGY EXAMPLE - BERKELEY COUNTY

1. CALCULATION OF THE ACTUAL TOTAL COUNTY HOME HEALTH UTILIZATION RATE.

(This compares county and state home health utilization rate).

- |    |  |                |
|----|--|----------------|
| a. | Show number of total home health recipients for county for current year from the Authority Home Health Survey. | <u>733</u>     |
| b. | Show county population for current year.   | <u>64962</u>   |
| c. | Divide a by b.   | <u>.011284</u> |
| d. | Multiply c by 1000 for the current county home health utilization rate.  | <u>11.28</u>   |
| e. | List current state home health utilization rate from Authority Home Health Survey.                             | <u>20.70</u>   |
| f. | Is the current county home health utilization rate below the state rate?                                       | yes/no         |

If yes, continue with the following. If no, an unmet need does not exist.

2. CALCULATION OF THE ACTUAL NUMBER OF HOME HEALTH RECIPIENTS NEEDED TO OBTAIN THE STATE UTILIZATION RATE.

A. Components of formula - a, b, c.

a =	List number of current home health recipients for county for current year (1.a)	<u>733</u>
b =	List county home health utilization rate for current year (1.d)	<u>11.28</u>
c =	List state home health utilization rate for current year (1.e)	<u>20.70</u>

Formula  $a \times c / b = d$

1.	Multiply a x c	<u>15173.1</u>
2.	Divide a x c by b	<u>1344</u>
d =	Number of home health recipients for county to meet state utilization rate	<u>1344</u>

3. CALCULATION OF THE ACTUAL NUMBER OF HOME HEALTH RECIPIENTS BELOW THE STATE RATE.

Formula  $a - b = c$

a.	List number of home health recipients for county to obtain state rate (2.d)	<u>1344</u>
b.	List current number of home health recipients for county (1.a)	<u>733</u>
c.	Subtract b from a to obtain the number of home health recipients <u>below</u> the state rate.	<u>611</u>

4. CALCULATION OF THE THRESHOLD (ADJUSTMENT FACTOR)

(This calculation is done only for agencies receiving CON approvals in previous 12 months.

Formula  $a - b = c$

a.	List the current county home health recipients <u>below</u> state rate (3.c)	<u>611</u>
b.	Subtract adjustment for agencies receiving CON approval in previous 12 months.	<u>0</u>
c.	Number <u>above</u> threshold adjustment.	<u>611</u>

Conclusion:

If the threshold is at least 229 projected home health recipients, an unmet need exists.

8. **CONSISTENCY WITH THE STATE HEALTH PLAN**

Provide an analysis of the project's consistency with the Standards for Home Health Services approved by the Governor on June 30, 1996. List each standard and demonstrate the extent to which the project meets each of these Standards.

9. **FINANCIAL FEASIBILITY**

For each of the most recently completed fiscal year, the current and next future fiscal years prior to the project's full completion, and for the first three years of operation after completion, submit the following information as applicable.

A. Financial statements

9.A.1 Statements of Revenues and Expenses

9.A.2 Balance Sheets

9.A.3 Statements of Changes in Fund Balances or Financial Position

B. Provide a listing of assumptions utilized in the preparation of the financial statements including staffing and salaries, expenses, utilization data, fee schedule or charges, and projected revenues based on payor mix in Table 9.

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10. **AVAILABILITY OF HEALTH SERVICES**

- A. Describe the relationship of this project to the existing health care system in the service area.
- B. How will this proposal enhance the availability of home health care to medically underserved areas?
- C. How will the proposed service affect the utilization and operation of existing health services in the service area?

11. **COST CONTAINMENT**

- A. Describe how this proposal will result in the efficient and effective delivery of home health care services.
- B. Discuss the availability of needed resources.
- C. What alternatives to the development of this proposal were considered?

12. **FACILITY POLICIES**

- A. How will the proposal fulfill the needs of medically indigent persons?
- B. What is your policy for acceptance of patients?

13. **LETTERS OF SUPPORT**

Attach letters of support and endorsements, if any.

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14. **SIGNATURE**

COUNTY OF \_\_\_\_\_

STATE OF \_\_\_\_\_, to wit:

Upon first being duly sworn, I hereby state that, to the best of my information, knowledge, and belief, the information provided in this application is true and correct. I further state that the applicant is in full compliance with the financial disclosure provisions of W.Va. Code §16-5F-1 et seq. or W.Va. Code §16-29B-1 et seq.

\_\_\_\_\_  
(Signature)

\_\_\_\_\_  
(Title)

Sworn, to stated, and subscribed before me on this \_\_\_\_\_ day of \_\_\_\_\_,  
\_\_\_\_\_.

\_\_\_\_\_  
Notary Public

(SEAL)

CON-30.5

CON File # \_\_\_\_\_

**TABLE 5**

**PROPOSED PLAN FOR FINANCING**

Complete applicable items and describe source, type, amount, rate, etc. Attach documentation, letters of commitment, additional information as pertinent.

<u>Type of Financing</u>	<u>Total Amount</u>
____ <b>Lease</b> (Check appropriate blanks)	_____
Land ____ Building ____ Equipment ____	
Fair Market Value \$ _____	
____ <b>Cash</b>	_____
Source: _____	
_____	
____ <b>Conventional</b>	_____
Principal \$ _____	
Interest \$ _____	
Term \$ _____	
____ <b>Bonds</b>	_____
Principal \$ _____	
Interest \$ _____	
Term \$ _____	
Debt Service Reserve \$ _____	
CON-30.6	_____

CON File # \_\_\_\_\_

**TABLE 5 (cont'd)**

_____ <b>Gifts</b>	_____
_____ <b>Grants</b>	_____
_____ <b>Land Equity</b>	_____
_____ <b>Other Owner Equity</b>	_____
Notes	\$ _____
Stock	\$ _____
Other	\$ _____
<b>TOTAL FINANCING</b>	_____



CON File # \_\_\_\_\_

**TABLE 6**

**PROJECT TIMEABLE**

Provide a timeable for incurring the obligation for any capital expenditure associated with the project and for implementation of the project.

	<u>Estimated Months Subsequent To CON Approval</u>
a. Land (site) acquired:	_____
b. Final plans and specifications submitted to the HFLC&S:	_____
c. Financing arrangements completed:	_____
d. Initial capital expenditure obligated:	_____
e. Construction contract secured and signed:	_____
f. Construction started:	_____
g. Remaining capital expenditure obligated	_____
h. Equipment orders submitted:	_____
i. Construction completed:	_____
j. Request for substantial compliance review submitted to CON Program:	_____
k. Project completed and in operation:	_____

CON-30.8

CON File # \_\_\_\_\_

**TABLE 9**

Provide the following information for the most recently completed fiscal year, current and future years prior to the project's completion and for the first[ year of operation after completion of the project. State all assumptions upon which the projections are based.

Year Ending \_\_\_\_\_

	<u>Gross Revenue</u>	<u>Allowance</u>	<u>Net Revenue</u>
Medicare	_____	_____	_____
Medicaid	_____	_____	_____
Blue Cross/ Blue Shield	_____	_____	_____
Commercial Insurance	_____	_____	_____
Self Pay	_____	_____	_____
Other	_____	_____	_____
Total *	_____	_____	_____

\* Total should correspond to operating revenue shown on pro-forma revenue and expense statements submitted for first year of operation.